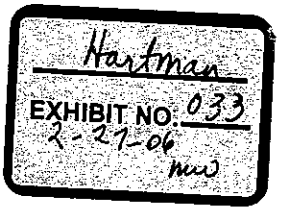

March 1997

Cancer Economics

Administration Proposes Cut Of Markup On Outpatient Drugs

The Administration's budget proposal for fiscal 1998 eliminates the markup on drugs and biologicals administered in physicians' offices and reimbursed under the Medicare program.

If adopted, the proposal would eliminate a major source of revenue for oncologists and, according to many observers, may lead physicians to administer chemotherapy in the hospitals, thereby actually increasing healthcare costs.

Under the existing law, Medicare reimburses 80 percent of the average wholesale price of a drug, and the patient pays the remaining 20 percent. Under the Administration's proposal, Medicare would reimburse 80 percent of the physicians' "actual acquisition cost."

In materials circulated on Capitol Hill, the American Society of Clinical Oncology said the proposal is "unworkable and unfair," and "may make it impossible for physicians to carry on their practices."

Under the Administration proposal, reimbursement would be the lowest of:

- The physician's actual acquisition cost.
- The average wholesale price.
- The median actual acquisition cost of all claims for the drug or biological for the 12-month period.

The proposal defines the actual acquisition cost as "the physician's... cost based on the most economical case size in inventory on the date of dispensing or, if less, the most economical case size purchased within six months of the date of dispensing whether that specific drug was furnished to an individual whether or not enrolled under this part. The actual acquisition cost includes all discounts, rebates, or any other benefit in cash or in kind (including, but not limited to, travel, equipment, or free products)."

Under the proposal, pharmacies could be paid "reasonable" dispensing fees.

In a critique of the proposal, ASCO said:

—The Proposal Is Not Based on True Acquisition Cost. Although ostensibly basing Medicare payment o

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Insurers Are Eliminating Markup On Cancer Drugs, Official Says

Health insurers are starting to eliminate the oncologists' markup on chemotherapy drugs, a senior managed care company official said at a meeting of the National Cancer Centers Network earlier this month.

"You are going to have to make chemotherapy a cost-neutral equation," Lee Newcomer, chief medical officer at United HealthCare Corp. of Minneapolis, said in a keynote address at the NCCN guideline conference March 3. "I will tell you that the industry is probably going to do this for you.

"Without [eliminating the markup on drugs], I really do fear that you are going to lose credibility withio organizations outside," said Newcomer, formerly a practicing oncologist. "Employers are already bringing this up to me What are you doing about oncologists who are making too much money on drugs?"

The excerpted text of Newcomer's remarks follows:

"You need to go out and measure your performance, and you need to do it tomorrow. The only thing that makes you different from anybody else down the street is what you can come back and show me that you do.

"When you [measure performance], a couple of things are going to happen. First, you are not going to

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ASCO Criticizes Administration Proposal On Drug Markup

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on a physician's acquisition cost, the proposal would actually establish arbitrary rules that are only remotely connected to the acquisition cost of the drug being reimbursed. Actual acquisition cost would be capped by a national median based on prices 6-18 months old regardless of current market conditions. These rules would result in out-of-pocket losses by physicians.

—The Proposal Ignores Costs Incurred by Physicians. Even if acquisition cost were accurately computed, reimbursement on that basis would not cover all the costs. Additional costs include staff time in procuring and storing the drug; the opportunity cost of the capital tied up in drug inventory; wastage and spillage; sales tax in several states; and unpaid coinsurance

—The Proposal Would Create an Accounting Nightmare for Physicians. Drug companies may offer pricing that covers more than one product; there may be year-end rebates based on the amount of drug purchased; the purchase of one product may earn a discount on another product; free vials may accompany a number of purchased vials, etc. Physician practices are in no position to sort through these complexities and determine the cost of each drug, but if they make any errors in calculating the cost of a particular drug, they may be charged with making false claims.

—The Proposal Would Lead to Overall Inadequate Reimbursement. The current payment system for drugs compensates for Medicare's gross underpayment for the administration service. Currently, the Medicare payment for the basic infusion service is only about $53 even though the direct costs (staff, supplies) of the service have been determined by Medicare to be $102 and total costs (including rent, utilities, etc.) may be about $185. Until Medicare rectifies the payment amount for the administration service, physicians rely on the drug payments to cover their costs. If their costs are not covered, physicians cannot carry on their practices.

—The Proposal Would Be Anti-Competitive. Under the proposal, physicians would have no incentive to seek lower drug prices and manufacturers would have no incentive to compete on the basis of price. Drug prices could rise as a result. Because of the adverse incentives of cost reimbursement, Medicare is moving away from other services.

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Health Insurance Official Says Industry Is Ending Markup

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like what you find. You are human. You are just like any other doctor out there. Your performance will not be good.

"But then you know where to start. And you know what to improve. And you know what to do next. . .

"At United HealthCare, we have a concept that I call accountable autonomy.

"I don't want to be in the business of micromanaging. What I want to do instead is say, here are the standards. This is what you need to get to. You get there the way that works best for you. It may be the NCCN guidelines. It may be something entirely different. It may be that you need to work with your hospital to become more efficient.

"What we want to do is set the standards and set the rewards for meeting those standards and get out of the way.

"I think these guidelines are too complex for the average practicing doctor. Maybe what they need to do is measure how well they do on five or three key points of those guidelines as a starting points. There are too many branches and trees out there that it would take a very sophisticated computer system to get it all

done. You might be able to do that at NCCN locations, but you probably aren't going to get it out of the average oncologist's office.

"Today there is no extra incentive or financial payment for collecting data, but it is your key to staying in business five—well, actually two-to-five—years from now. Because the people who can come in and say, I can perform at an X level, and I have the data to prove it are the people who are going to be differentiated.

"Already, this year, we've gone to all the centers in our network who do high dose chemotherapy with some type of hematologic rescue, and we've set performance standards. For each diagnosis and stage, we said you have to hit this survival, and if you don't we are going to find someone else who can. What we are interested in is performance; not production.

"The second thing I'd ask you to do is become the personal care physician for the cancer patient. My fear for medical oncologists is that they are becoming nothing more than chemotherapy technicians. When you look at what's happened to oncology practices over the last five years, they've gone from being the cancer consultants to being chemotherapy givers.

"My case managers are coming to me and saying that about half my patients are dying within two weeks of their last chemotherapy course. So where was the oncologist saying, it's time for palliative care. Let me give you good supportive care and pain relief. Let me get you into a hospice. Let me help you with those things that are now important at this stage of your illness. Instead what is happening is they continue to get treated, and treated, and treated.

"And more and more we are finding that the type of treatment you get is directly related to which doctor you see first. If you are dealing with a cancer that has three options, surgery, radiation and oncology, what happens is you get surgery if you see a surgeon, radiation therapy if you see a radiologist, and chemotherapy if you see an oncologist.

"I think the oncologist should be the gateway for these folks into all the rest of the healthcare system. But to do that, you have to remain the general consultant for oncology.

"The markups for chemotherapy medicines are getting to be so high that the public is beginning to react. You are losing credibility from that. What you will see happening in my company and, I suspect, others, is that you will no longer be getting reimbursed at [Average Wholesale Price]. You will be getting reimbursed at catalogue prices. The reason for doing that is to make this decision truly a decision made because it's the right thing to do; not because you have a financial incentive.

"You shouldn't be making the decisions with the incentive that may not be the right incentive for you.

"We are on a brand new horizon in medical care. We have not known it, but we have been going along with mediocre performance for a long time. The next decade is going to bring superb performance."

In other developments at NCCN:

—The Network which includes 15 academic cancer centers, presented its clinical guidelines for sarcoma, melanoma, and cancers of the brain, head and neck, bladder and the pancreas, as well as a guideline on the use of antiemetics.

—Robert Young replaced Joseph Simone as NCCN chairman of the board. Young, formerly NCCN vice chairman, is president of Fox Chase Cancer Center. Simone is executive director of Huntsman Cancer Care Program.

Oncology Management

AOR, Immunex In Partnership On Studies Of Firm's Products

American Oncology Resources Inc., (Nasdaq: AORI) of Houston, and **Immunex Corp.** (Nasdaq: IMNX) of Seattle have formed a Disease Management Partner Program, the companies said.

According to the companies, the program is designed to improve cost effectiveness of cancer treatment delivered by the AOR network.

Under the agreement, AOR physicians will be involved in clinical studies of Immunex products, including a multi-state study of Novantron in advanced prostate cancer patients, the companies said. Immunex will supply 5 cancer-related therapeutics including Leukine (sargramostim) and Novantrone (mitoxantrone for injection concentrate) as well as generic products.

* * *

Joseph Welfeld was named president and CEO of **Affiliated Physicians Network Inc.** of White Plains, NY, a regional network of 120 physicians specializing in oncology.

Welfeld, most recently a consultant, is the former CEO of Ocean State Physicians Health Plan Inc., and regional vice president of United HealthCare Corp.

APN serves the New York metropolitan area

ASCO Tells Medicare What Is Acceptable

ALEXANDRIA, Va.—The American Society of Clinical Oncology has laid its cards on the table in the impending struggle over Medicare reimbursement for cancer drugs and their administration in the office.

In a "white paper" posted on its Web site this month, ASCO concluded that practice expenses covered by Medicare need to be revised to cover the true costs incurred by physicians in providing chemotherapy services. ASCO also asked that Medicare cover cognitive services as well.

At the same time, ASCO agreed that Medicare payment for drugs could be based on government surveys of wholesaler selling prices, or on the existing average wholesale price system "as modified to limit the permissible difference between actual selling price and published average wholesale price."

In a line in the sand on drug-cost reimbursement, ASCO proposed that three criteria were essential. Payments should be set at amounts that will cover the costs incurred by the vast majority of oncologists and should not require oncologists to alter their typical current procurement method of buying drugs from one or two wholesalers.

Any payment system based on an estimate of market prices should include a 10% add-on to cover additional drug-related costs, such as inventory expenses, bad debt, and wastage. Medicare should also pay state and local sales taxes and gross receipts taxes.

ASCO rejected the concept of a system of reimbursing each physician for the specific costs incurred by the physician for drugs administered to Medicare patients, contending that this has serious defects.

Meanhile, Brian McCagh, executive director of the Washington Cancer Institute, part of 791-bed Washington (D.C.) Hospital Center, was quoted this week in *Modern Healthcare* as summing up the issue bluntly.

"For many of the private-practice oncologists, it's not uncommon where up to 50% of their annual take-home pay can be tied directly back to the markup on the drugs they prescribe in their cancer practice," the magazine quoted McCagh, a former president of the Association of Cancer Executives, as saying. "How much longer will HCFA allow us to buy something for X (dollars) and try to sell it for three or four (times) X? Eventually, HCFA and managed-care organizations will crack down on this, and the question is just how much will they chip away at those margins."

Imatinib Resistance

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In accelerated-phase CML, the phase-2 data showed a 69% hematologic response lasting four or more weeks—an increase from the 63% hematologic response reported in February. About 70% of patients remain free of progression to the blast crisis after a year of treatment, the company reported.

In blast crisis, the updated data indicate that 52% of patients had some hematologic response, with 25% showing a sustained response for at least four weeks—up from the 26% reported in February.

And 55% of the patients who had achieved a hematologic response in the blast crisis phase have maintained it for six months or more, an estimated median duration of response of 8.3 months. For the entire blast crisis cohort, irrespective of response, the median survival rate is seven months, vs. three to six months for historical controls.

In the Pipeline